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No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,

Petitioners,

vs.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, and ADMINISTRATION OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON

Respondents,

vs.

THAD C. MCCANSE, Guardian ad litem,

BRIEF OF WASHINGTON UNIVERSITY, BARNES HOSPITAL, JEWISH HOSPITAL, ST. LOUIS CHILDREN'S HOSPITAL, AND ST. LUKE'S EPISCOPAL-PRESBYTERIAN HOSPITALS AS AMICI CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE MISSOURI SUPREME COURT

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STATEMENT OF INTEREST OF AMICI CURIAE

This Brief is submitted on behalf of Washington University, Barnes Hospital, Jewish Hospital, St. Louis Children's Hospital, and St. Luke's Episcopal-Presbyterian Hospitals;

each of which is a Missouri not-for-profit institution located in St. Louis, Missouri.[1]

Washington University maintains a School of Medicine devoted to teaching, research and patient care. In 1988, one hundred twenty-four (124) students graduated from the School of Medicine. Most of the graduating medical students accepted positions outside of Missouri. The University employs four hundred seventy (470) full-time physicians who are called upon frequently to make recommendations to patients, families, hospital administration, and the courts relative to medical treatment including institution and withdrawal of life support measures.

Barnes Hospital operates a tertiary care hospital with twelve hundred eight (1,208) licensed beds. The Jewish Hospital operates a tertiary care hospital with six hundred twenty-eight (628) licensed beds. St. Louis Children's Hospital operates a pediatric tertiary care hospital with one hundred thirty-five (135) licensed beds including fifty-two (52) neonatal intensive care bassinets and twenty-two (22) pediatric intensive care beds. St. Luke's Episcopal-Presbyterian Hospitals operates an acute care hospital with four hundred ninety-seven (497) licensed beds. All four hospitals serve as regional referral centers for many high risk patients and for the performance of specialized medical and surgical procedures. Hospital administration, physicians, and nurses at each are frequently consulted and become involved in life support issues.

Washington University, Barnes Hospital, Jewish Hospital, and St. Louis Children's Hospital jointly comprise the Washington University Medical Center and co-sponsor several graduate medical internship, residency, and fellowship programs accredited by the Accreditation Council for Graduate

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[1] The parties to this litigation have consented to the filing of this *Amici Curiae* Brief via letters on file with the Clerk.

Medical Education. In 1988, there were nine hundred forty-two (942) physicians enrolled in these programs at the Washington University Medical Center. Upon completion of these programs, many of these physicians accept positions throughout the United States.

St. Luke's Episcopal-Presbyterian Hospitals sponsors a graduate medical residency program also accredited by the Accreditation Council for Graduate Medical Education. In 1988 there were forty-nine (49) physicians in the program. This number includes four (4) physicians engaged in a cardiology fellowship. Upon completion of the program, these residents accept positions throughout the United States.

The legal, ethical, and societal issues presented in *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. en banc. 1988) affect *Amici*, their patients, students, and employees in many significant ways. For example, the decision clouds issues regarding treatment options for patients who come from many states, complicates education and clinical training of medical students and graduate physicians, runs contrary to the generally accepted ethical and legal duties of the medical employees of the institutions, and compounds the problems of social support for gravely ill patients and their families.

Amici request that this Court grant certiorari to review, clarify, and set forth the constitutional boundaries of withholding and removing life support equipment and means.

ARGUMENT

While the *Cruzan* majority attempts to limit the scope of its holding to the narrow facts presented, the opinion has many inconsistencies and many far reaching effects beyond those just for patients in a persistent vegetative state ("PVS") with guardians attempting to remove a gastrostomy tube. Petitioners have fully addressed the constitutional issues presented to this Court, and this Brief will address some of the more practical effects of the *Cruzan* opinion.

The majority concedes that its opinion runs counter to those from other jurisdiction which have "[n]early unanimously" granted the request of the patient or guardian. *Cruzan,* 760 S.W.2d at 413. The Court attempts to distinguish those cases by arguing that this is not a case where the court was asked to let someone die, but, rather, "is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration." *Cruzan,* 760 S.W.2d at 412. This is an emotional gloss that begs the question of what the proper standard is for removal of life support.

In all of the "right to die" cases, the termination of life support of one kind or another will hasten death. If that were not true, there would be no legal issue for the courts to decide. The more important question is who can decide to withhold life support and when.

All of the courts that have addressed "right to die" issues, including the *Cruzan* court, have conceded that the patient does have a constitutional right to privacy allowing free choice relative to their medical care. *See, e.g., Tune v. Walter Reed Hospital,* 602 F. Supp. 1452 (D.D.C. 1985). The state interests identified in these cases encompass the preservation of life, the prevention of suicide, the protection of interests of innocent third parties, and the maintenance of the ethical integrity of the medical profession. *See Brophy v. New England Sinai Hosp.,* 398 Mass. 417, 432, 497 N.E.2d 626, 634 (1986).

Every court faced with the request of a lucid patient to terminate life support has ruled that such individual's constitutional right to privacy clearly outweighs the above state interests. *See, e.g., Bouvia v. Super. Ct. of Los Angeles,* 179 Cal. App.3d 1127, 225 Cal. Rptr. 297 (1986) (removal of nasogastric feeding tube). However, when faced with the request of a guardian seeking the same relief on behalf of a PVS or comatose patient, the courts have struggled to balance the patient's privacy rights with state interests. *See, e.g., Brophy, supra* (applying "substituted judgment" standard in authorizing wife/guardian of a PVS patient to order removal of gastric tube); *In re Conroy,* 98 N.J. 321, 486 A.2d 1209 (1985) (three tests established: subjective test, limited-objective test, and pure-objective test depending upon the quantum of evidence of the patient's desire to terminate life sustaining treatment).

Amici suggest that there should be no legal distinction between these two settings. Surely, the scales used to balance the patient's constitutional privacy rights with the state's interests are the same irrespective of the patient's condition. To argue that the comatose or PVS patient has less privacy rights than the lucid patient, runs counter to traditional constitutional principles.

The *Cruzan* majority was also swayed by the fact that Nancy Cruzan was not terminally ill. *Cruzan,* 760 S.W.2d at 419. However, life expectancy should not shift the scales of justice. Arguably, the fact that the feeding tube might remain for a long period of time makes the treatment more invasive and intrusive. Under similar circumstances, the court in *Brophy* declared such treatment intrusive and extraordinary as a matter of law. *Brophy,* 398 Mass. at 435, 497 N.E.2d at 636. *See also In re Peter,* 108 N.J. 365, 374, 529 A.2d 419, 424 (1987) (establishing a "prognosis approach" for PVS patients with a normal life expectancy and authorizing removal of a nasogastric feeding tube on a PVS patient because there was no reasonable possibility of return to a cognitive and sapient life). This dichotomy between

patient types runs throughout the *Cruzan* majority opinion and is not legally supportable.

The *Cruzan* majority also stumbled on the statutory power of a guardian to discontinue treatment. The majority conceded that a guardian can consent to medical treatment but rejected the notion that a guardian has the statutory authority to withdraw medical treatment. *Cruzan,* 760 S.W.2d at 424-26; Mo. Rev. Stat. §475.120.3 (1986). This, too, misses the mark. The power to consent to a "future" medical task surely includes the power to reject or withhold a "future" medical task. Either can lead to death of the ward. The decision is still made in the best interests of the ward. Surely, if the guardian has the right to reject a type of treatment, the guardian has the right to withdraw the same type of treatment.

This principle was recognized by this Court in *Thompson v. Oklahoma,* 487 U.S. ____, 108 S. Ct. 2687, 101 L. Ed.2d 702 (1988) (plurality opinion). *Thompson* involved a minor who was convicted of first degree murder and sentenced to death. The issue presented was whether execution of the sentence would violate the constitutional prohibition against cruel and unusual punishment because the Petitioner was only 15 years old at the time of the offense. The Court recognized that "[t]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally," noting that "those who are irreversibly ill with loss of brain function ... retain 'rights,' to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind." *Thompson,* 487 U.S. at ____ n. 23, 108 S. Ct. at 2693 n. 23, 101 L.Ed.2d at 712 n. 23 (citing Garvey, FREEDOM AND CHOICE IN CONSTITUTIONAL LAW, 94 Harv. L. Rev. 1756 (1981)).

This weakness in the *Cruzan* opinion will only serve to exacerbate the problem. Rather than risk being denied the right to remove a gastrostomy tube, many patients and their families

may decide to simply forego insertion of the tube and run the "risk" of poor nutrition and hydration. This can often be medically counterproductive because such a tube may be the extra support needed by the patient to pull through a medical crisis. This negative impact on true medical decisions has been recognized by the courts. *See In re Conroy,* 98 N.J. 321, 486 A.2d 1209 (1985). The court in that case was presented with the request of a guardian to remove a gastrostomy tube on behalf of a comatose patient who had not previously expressed any sentiment on life support. The court noted:

> Moreover, from a policy stand-point, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die

In re Conroy, 98 N.J. at 370, 46 A.2d at 1234. *See also Gray v. Romeo,* 697 F. Supp. 580, 588 n. 4 (D. RI. 1988) (authorizing husband/guardian of unconscious patient to remove feeding tube and life support of spouse in PVS). The *Cruzan* holding will only serve to chill full and frank discussions between patients, their family, and their physicians, and create doubt in the minds of the decision-makers at a time when they do not have days or weeks to reflect on their decision.

The *Cruzan* majority also distinguishes between the removal of some life support such as by respirator, and the removal of a gastrostomy tube providing nutrition and hydration. *Cruzan,* 760 S.W.2d 422-23. This is not a valid legal or medical distinction. The nutrition being supplied to Nancy Cruzan is in the form of an FDA approved drug, requiring a doctor's order just as a respirator requires a doctor's order. The drug is keeping her alive in the same fashion as the respirator does for patients unable to breathe on their own. The courts addressing this issue

have concluded that no analytical difference exists between artificial feeding and other life support measures. *See, e.g., In re Gardner,* 534 A.2d 947, 954 (Me. 1987); *Brophy,* 398 Mass. at 435-39, 397 N.E.2d at 636-38; *In re Jobes,* 108 N.J. 394, 413 n. 9, 529 A.2d 434, 444 n. 9, *stay denied sub. nom. Lincoln Park Nursing and Convalescent Home v. Kahn,* 483 U.S. ____, 108 S. Ct. 6, 97 L. Ed. 2d 796 (1987). As stated by the court in *Gray:* "[a]lthough an emotional symbolism attaches itself to artificial feeding, there is no legal difference between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment. If a person has the right to decline life on a respirator, *Tune,* 602 F. Supp. at 1455-56, then a person has the equal right to decline a gastrostomy tube." *Gray,* 697 F. Supp. at 587.

The prevailing theological principles, while recognizing the sanctity of human life, do not mean that life must be sustained at all costs; that every means of modern technology must be employed to maintain a dying individual. Paris, TERMINATING TREATMENT FOR NEWBORNS, A THEOLOGICAL PERSPECTIVE, 10 Law, Medicine and Health Care 120 (June 1982). The teaching that one is not obligated to use every possible means to keep a person alive has its roots dating back to St. Thomas Aquinas. 11 Kelly Theological Studies 203 (1950).

Decisions on medical treatment and the withholding or withdrawal of medical treatment are best left to the patient in concert with his/her family and clergy. If the patient is not competent, then the same decisions are best left to the patient's guardian, family, physicians, and clergy. As numerous courts have noted, those are the persons best able to decipher the intent of the patient. *See, e.g., In re Quinlan,* 70 N.J. 10, 355 A.2d 647 (1976). Recourse to the courts is too tempting. However, not every life and death value conflict confronting the medical professions can be resolved by a judge. Judges should not be mistaken for clergy in black vestments. Legislators should not be mistaken for Delphic oracles. Our legal system, with all of its

positive virtues cannot replace the more intimate struggle among those caring for the patient to resolve these questions.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari to the Missouri Supreme Court should be granted.

Respectfully submitted,

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